M.I .N.I (MINI INTERNATIONAL NEUROPSYCHIATRIC INTERVIEW)

The M.I.N.I. is a self-report psychiatric interview that screens for various mental health conditions. The more open you are in your responses the more this will help in your overall mental health assessment and in treatment planning. The results of this screening interview do not determine whether you have a psychiatric disorder but will help in what is focused on during the clinical interview you have with the doctor.

Each section begins with a shaded area that consists of brief screening questions. If your answer at the end of each shaded area is "No", the "→" symbol means you do not have to answer the rest of the questions on that page and should instead move on to the shaded area in the next major section you come to (except for p 8 which you should answer regardless of your previous responses).

For example, if after answering A1 and A2 on page 5, you circle the "No" with the "→" above it in the shaded area you can move on to page 6 without answering the questions in the non-shaded area on page 5.

If your answer at the end of each shaded area is "Yes", then you should answer the remaining questions on the rest of that page (in the non-shaded area) before moving on to the next major section.

Please take your time in answering the sixteen sections listed below (A→P) starting with the first page labeled 5.

A. MAJOR DEPRESSIVE EPISODE (pp 5-6)

B. DYTHYMIA (p 7)

C. SUICIDALITY (p 8)

D. (HYPO) MANIC EPISODE (pp 9-10)

E. PANIC DISORDER (p 11)

F. AGOROPHOBIA (p 12)

G. SOCIAL PHOBIA (p 13)

H. OBSESSIVE-COMPULSIVE DISORDER (p 14)

I. POSTTRAUMATIC STRESS DISORDER (p 15)

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M. ANOREXIA NERVOSA (p 22)

N. BULIMIA NERVOSA (p 23)

O. GENERALIZED ANXIETY DISORDER (p 24)

P. ANTISOCIAL PERSONALITY DISORDER (p 25)

A. MAJOR DEPRESSIVE EPISODE

(⇨ MEANS : GO TO THE DIAGNOSTIC BOXES, CIRCLE NO IN ALL DIAGNOSTIC BOXES, AND MOVE TO THE NEXT MODULE)

A1	Have you been consistently depressed or down, most of the day, nearly every day, for the past two weeks?	NO	YES
A2	In the past two weeks, have you been much less interested in most things or much less able to enjoy the things you used to enjoy most of the time?	NO	YES
	IS A1 OR A2 CODED YES?	⇨ NO	YES
A3	**Over the past two weeks, when you felt depressed or uninterested:**		
a	Was your appetite decreased or increased nearly every day? Did your weight decrease or increase without trying intentionally (i.e., by ±5% of body weight or ±8 lbs. or ±3.5 kgs., for a 160 lb./70 kg. person in a month)? IF YES TO EITHER, CODE YES.	NO	YES *
b	Did you have trouble sleeping nearly every night (difficulty falling asleep, waking up in the middle of the night, early morning wakening or sleeping excessively)?	NO	YES
c	Did you talk or move more slowly than normal or were you fidgety, restless or having trouble sitting still almost every day?	NO	YES *
d	Did you feel tired or without energy almost every day?	NO	YES
e	Did you feel worthless or guilty almost every day?	NO	YES
f	Did you have difficulty concentrating or making decisions almost every day?	NO	YES
g	Did you repeatedly consider hurting yourself, feel suicidal, or wish that you were dead?	NO	YES

ARE 5 OR MORE ANSWERS (A1-A3) CODED YES?

NO YES *

MAJOR DEPRESSIVE EPISODE, CURRENT

IF PATIENT HAS CURRENT MAJOR DEPRESSIVE EPISODE CONTINUE TO A4, OTHERWISE MOVE TO MODULE B:

A4	a During your lifetime, did you have other episodes of two weeks or more when you felt depressed or uninterested in most things, and had most of the problems we just talked about?	⇨ NO	YES
	b In between 2 episodes of depression, did you ever have an interval of at least 2 months, without any depression and any loss of interest?		

NO YES

MAJOR DEPRESSIVE EPISODE, RECURRENT

* If patient has Major Depressive Episode, Current, use this information in coding the corresponding questions on page 5 (A6d, A6e).

MAJOR DEPRESSIVE EPISODE WITH MELANCHOLIC FEATURES (optional)

(➪ MEANS : GO TO THE DIAGNOSTIC BOX, CIRCLE NO, AND MOVE TO THE NEXT MODULE)

IF THE PATIENT CODES POSITIVE FOR A CURRENT MAJOR DEPRESSIVE EPISODE (A3 = YES), EXPLORE THE FOLLOWING:

A5 a During the most severe period of the current depressive episode, did you lose almost completely your ability to enjoy nearly everything? NO YES

b During the most severe period of the current depressive episode, did you lose your ability to respond to things that previously gave you pleasure, or cheered you up?
IF NO: When something good happens does it fail to make you feel better, even temporarily? NO YES

➪

IS EITHER A5a OR A5b CODED YES?

A6 **Over the past two week period, when you felt depressed and uninterested:**

a Did you feel depressed in a way that is different from the kind of feeling you experience when someone close to you dies? NO YES

b Did you feel regularly worse in the morning, almost every day? NO YES

c Did you wake up at least 2 hours before the usual time of awakening and have difficulty getting back to sleep, almost every day? NO YES

d IS A3c CODED YES (PSYCHOMOTOR RETARDATION OR AGITATION)? NO YES

e IS A3a CODED YES FOR ANOREXIA OR WEIGHT LOSS? NO YES

f Did you feel excessive guilt or guilt out of proportion to the reality of the situation? NO YES

ARE 3 OR MORE A6 ANSWERS CODED YES?

NO YES

Major Depressive Episode with Melancholic Features Current

B. DYSTHYMIA

(⇨ MEANS : GO TO THE DIAGNOSTIC BOX, CIRCLE NO, AND MOVE TO THE NEXT MODULE)

IF PATIENT'S SYMPTOMS CURRENTLY MEET CRITERIA FOR MAJOR DEPRESSIVE EPISODE, DO NOT EXPLORE THIS MODULE.

B1	Have you felt sad, low or depressed most of the time for the last two years?	⇨ NO	YES
B2	Was this period interrupted by your feeling OK for two months or more?	NO	⇨ YES
B3	**During this period of feeling depressed most of the time:**		
a	Did your appetite change significantly?	NO	YES
b	Did you have trouble sleeping or sleep excessively?	NO	YES
c	Did you feel tired or without energy?	NO	YES
d	Did you lose your self-confidence?	NO	YES
e	Did you have trouble concentrating or making decisions?	NO	YES
f	Did you feel hopeless?	NO	YES
	ARE 2 OR MORE B3 ANSWERS CODED YES?	⇨ NO	YES
B4	Did the symptoms of depression cause you significant distress or impair your ability to function at work, socially, or in some other important way?		

NO	YES
	DYSTHYMIA CURRENT

C. SUICIDALITY

	In the past month did you:			Points
		NO	YES	0
C1	Suffer any accident? IF NO TO C1, SKIP TO C2; IF YES, ASK C1a,:	NO	YES	0
C1a	Plan or intend to hurt yourself in that accident either passively or actively? IF NO TO C1a, SKIP TO C2: IF YES, ASK C1b,:	NO	YES	0
C1b	Did you intend to die as a result of this accident?	NO	YES	1
C2	Think that you would be better off dead or wish you were dead?	NO	YES	2
C3	Want to harm yourself or to hurt or to injure yourself?	NO	YES	6
C4	Think about suicide?			

IF YES, ASK ABOUT THE INTENSITY AND FREQUENCY OF THE SUICIDAL IDEATION:

Frequency		Intensity	
Occasionally	☐	Mild	☐
Often	☐	Moderate	☐
Very often	☐	Severe	☐

→ Can you control these impulses and state that you will not act on them while in this program? Only score 8 points if response is NO. NO YES 8

		NO	YES	8
C5	Have a suicide plan?	NO	YES	9
C6	Take any active steps to prepare to injure yourself or to prepare for a suicide attempt in which you expected or intended to die?	NO	YES	4
C7	Deliberately injure yourself without intending to kill yourself?	NO	YES	10
C8	Attempt suicide? Hoped to be rescued / survive ☐ Expected / intended to die ☐			
	In your lifetime:	NO	YES	4
C9	Did you ever make a suicide attempt?			

IS AT LEAST 1 OF THE ABOVE (EXCEPT C1) CODED YES?

NO YES

IF YES, ADD THE TOTAL NUMBER OF POINTS FOR THE ANSWERS (C1-C9) CHECKED 'YES' AND SPECIFY THE LEVEL OF SUICIDE RISK AS INDICATED IN THE DIAGNOSTIC BOX:

SUICIDE RISK CURRENT

1-8 points	Low	☐
9-16 points	Moderate	☐
≥ 17 points	High	☐

MAKE ANY ADDITIONAL COMMENTS ABOUT YOUR ASSESSMENT OF THIS PATIENT'S CURRENT AND NEAR FUTURE SUICIDE RISK IN THE SPACE BELOW:

D. (HYPO) MANIC EPISODE

(➪ MEANS : GO TO THE DIAGNOSTIC BOXES, CIRCLE NO IN ALL DIAGNOSTIC BOXES, AND MOVE TO THE NEXT MODULE)

D1 a Have you ever had a period of time when you were feeling 'up' or 'high' or 'hyper' or so full of energy or full of yourself that you got into trouble, or that other people thought you were not your usual self? (Do not consider times when you were intoxicated on drugs or alcohol.) — NO YES

IF PATIENT IS PUZZLED OR UNCLEAR ABOUT WHAT YOU MEAN BY 'UP' OR 'HIGH' OR 'HYPER', CLARIFY AS FOLLOWS: By 'up' or 'high' or 'hyper' I mean: having elated mood; increased energy; needing less sleep; having rapid thoughts; being full of ideas; having an increase in productivity, motivation, creativity, or impulsive behavior.

IF NO, CODE NO TO **D1b**: IF YES ASK:

b Are you currently feeling 'up' or 'high' or 'hyper' or full of energy? — NO YES

D2 a Have you ever been persistently irritable, for several days, so that you had arguments or verbal or physical fights, or shouted at people outside your family? Have you or others noticed that you have been more irritable or over reacted, compared to other people, even in situations that you felt were justified? — NO YES

IF NO, CODE NO TO **D2b**: IF YES ASK:

b Are you currently feeling persistently irritable? — NO YES

IS **D1a** OR **D2a** CODED **YES**? ➪ NO YES

D3 IF **D1b** OR **D2b** = **YES**: EXPLORE THE **CURRENT** AND THE MOST SYMPTOMATIC **PAST** EPISODE, OTHERWISE
IF **D1b** AND **D2b** = **NO**: EXPLORE ONLY THE MOST SYMPTOMATIC **PAST** EPISODE

During the times when you felt high, full of energy, or irritable did you:	Current Episode		Past Episode	
	NO	YES	NO	YES
a Feel that you could do things others couldn't do, or that you were an especially important person? IF YES. ASK FOR EXAMPLES. THE EXAMPLES ARE CONSISTENT WITH A DELUSIONAL IDEA. ☐ No ☐ Yes	NO	YES	NO	YES
b Need less sleep (for example, feel rested after only a few hours sleep)?	NO	YES	NO	YES
c Talk too much without stopping, or so fast that people had difficulty understanding?	NO	YES	NO	YES
d Have racing thoughts?	NO	YES	NO	YES
e Become easily distracted so that any little interruption could distract you?	NO	YES	NO	YES
f Become so active or physically restless that others were worried about you?	NO	YES	NO	YES
g Want so much to engage in pleasurable activities that you ignored the risks or consequences (for example, spending sprees, reckless driving, or sexual indiscretions)?	NO	YES	NO	YES

	Current Episode		Past Episode	
	NO	YES	NO	YES

D3 (SUMMARY): ARE 3 OR MORE D3 ANSWERS CODED YES
(OR 4 OR MORE IF D1a IS NO (IN RATING PAST EPISODE) AND D1b IS NO (IN RATING CURRENT EPISODE)?
RULE: ELATION/EXPANSIVENESS REQUIRES ONLY THREE D3 SYMPTOMS WHILE IRRITABLE MOOD ALONE REQUIRES 4 OF THE D3 SYMPTOMS.

VERIFY IF THE SYMPTOMS OCCURRED DURING THE SAME TIME PERIOD.

		Current Episode		Past Episode	
		NO	YES	NO	YES
D4	Did these symptoms last at least a week and cause significant problems at home, at work, socially, or at school, or were you hospitalized for these problems?	↓	↓	↓	↓
	THE EPISODE EXPLORED WAS A:	☐ *HYPOMANIC EPISODE*	☐ *MANIC EPISODE*	☐ *HYPOMANIC EPISODE*	☐ *MANIC EPISODE*

IS D4 CODED NO?

SPECIFY IF THE EPISODE IS CURRENT OR PAST.

NO	YES
HYPOMANIC EPISODE	
CURRENT	☐
PAST	☐

IS D4 CODED YES?

SPECIFY IF THE EPISODE IS CURRENT OR PAST.

NO	YES
MANIC EPISODE	
CURRENT	☐
PAST	☐

E. PANIC DISORDER

(⇨ MEANS : CIRCLE NO IN E5, E6 AND E7 AND SKIP TO F1)

E1	a	Have you, on more than one occasion, had spells or attacks when you **suddenly** felt anxious, frightened, uncomfortable or uneasy, even in situations where most people would not feel that way?	⇨ NO	YES
	b	Did the spells surge to a peak within 10 minutes of starting?	⇨ NO	YES
E2		At any time in the past, did any of those spells or attacks come on unexpectedly or occur in an unpredictable or unprovoked manner?	⇨ NO	YES
E3		Have you ever had one such attack followed by a month or more of persistent concern about having another attack, or worries about the consequences of the attack or did you make a significant change in your behavior because of the attacks (e.g., shopping only with a companion, not wanting to leave your house, visiting the emergency room repeatedly, or seeing your doctor more frequently because of the symptoms?	NO	YES
E4		**During the worst spell that you can remember:**		
	a	Did you have skipping, racing or pounding of your heart?	NO	YES
	b	Did you have sweating or clammy hands?	NO	YES
	c	Were you trembling or shaking?	NO	YES
	d	Did you have shortness of breath or difficulty breathing?	NO	YES
	e	Did you have a choking sensation or a lump in your throat?	NO	YES
	f	Did you have chest pain, pressure or discomfort?	NO	YES
	g	Did you have nausea, stomach problems or sudden diarrhea?	NO	YES
	h	Did you feel dizzy, unsteady, lightheaded or faint?	NO	YES
	i	Did things around you feel strange, unreal, detached or unfamiliar, or did you feel outside of or detached from part or all of your body?	NO	YES
	j	Did you fear that you were losing control or going crazy?	NO	YES
	k	Did you fear that you were dying?	NO	YES
	l	Did you have tingling or numbness in parts of your body?	NO	YES
	m	Did you have hot flushes or chills?	NO	YES
E5		ARE BOTH E3, AND 4 OR MORE E4 ANSWERS, CODED YES?	NO	YES *PANIC DISORDER LIFETIME*
		IF YES TO E5, SKIP TO E7.		
E6		IF E5 = NO, ARE ANY E4 ANSWERS CODED YES?	NO	YES *LIMITED SYMPTOM ATTACKS LIFETIME*
		THEN SKIP TO F1.		
E7		In the past month, did you have such attacks repeatedly (2 or more) followed by persistent concern about having another attack?	NO	YES *PANIC DISORDER CURRENT*

F. AGORAPHOBIA

F1 Do you feel anxious or uneasy in places or situations where you might have a panic attack or the panic-like symptoms we just spoke about, or where help might not be available or escape might be difficult: like being in a crowd, standing in a line (queue), when you are alone away from home or alone at home, or when crossing a bridge, traveling in a bus, train or car? NO YES

IF F1 = NO, CIRCLE NO IN F2.

F2 Do you fear these situations so much that you avoid them, or suffer through them, or need a companion to face them? NO YES

AGORAPHOBIA CURRENT

IS F2 (CURRENT AGORAPHOBIA) CODED NO

and

IS E7 (CURRENT PANIC DISORDER) CODED YES?

NO YES

PANIC DISORDER without Agoraphobia CURRENT

IS F2 (CURRENT AGORAPHOBIA) CODED YES

and

IS E7 (CURRENT PANIC DISORDER) CODED YES?

NO YES

PANIC DISORDER with Agoraphobia CURRENT

IS F2 (CURRENT AGORAPHOBIA) CODED YES

and

IS E5 (PANIC DISORDER LIFETIME) CODED NO?

NO YES

AGORAPHOBIA, CURRENT without history of Panic Disorder

G. SOCIAL PHOBIA (Social Anxiety Disorder)

(⇨ MEANS : GO TO THE DIAGNOSTIC BOX, CIRCLE NO AND MOVE TO THE NEXT MODULE)

		⇨ NO	YES
G1	In the past month, were you fearful or embarrassed being watched, being the focus of attention, or fearful of being humiliated? This includes things like speaking in public, eating in public or with others, writing while someone watches, or being in social situations.		
G2	Is this social fear excessive or unreasonable?	⇨ NO	YES
G3	Do you fear these social situations so much that you avoid them or suffer through them?	⇨ NO	YES
G4	Do these social fears disrupt your normal work or social functioning or cause you significant distress?		

SUBTYPES

Do you fear and avoid 4 or more social situations?

If YES Generalized social phobia (social anxiety disorder)

If NO Non-generalized social phobia (social anxiety disorder)

NOTE TO INTERVIEWER: PLEASE ASSESS WHETHER THE SUBJECT'S FEARS ARE RESTRICTED TO NON-GENERALIZED ("ONLY 1 OR SEVERAL") SOCIAL SITUATIONS OR EXTEND TO GENERALIZED ("MOST") SOCIAL SITUATIONS. "MOST" SOCIAL SITUATIONS IS USUALLY OPERATIONALIZED TO MEAN 4 OR MORE SOCIAL SITUATIONS, ALTHOUGH THE DSM-IV DOES NOT EXPLICITLY STATE THIS.

EXAMPLES OF SUCH SOCIAL SITUATIONSTYPICALLY INCLUDE INITIATING OR MAINTAINING A CONVERSATION, PARTICIPATING IN SMALL GROUPS, DATING, SPEAKING TO AUTHORITY FIGURES, ATTENDING PARTIES, PUBLIC SPEAKING, EATING IN FRONT OF OTHERS, URINATING IN A PUBLIC WASHROOM, ETC.

NO YES

SOCIAL PHOBIA
(Social Anxiety Disorder)
CURRENT

GENERALIZED ☐

NON-GENERALIZED ☐

H. OBSESSIVE-COMPULSIVE DISORDER

(⇨ MEANS: GO TO THE DIAGNOSTIC BOX, CIRCLE NO AND MOVE TO THE NEXT MODULE)

H1 In the past month, have you been bothered by recurrent thoughts, impulses, or images that were unwanted, distasteful, inappropriate, intrusive, or distressing? (For example, the idea that you were dirty, contaminated or had germs, or fear of contaminating others, or fear of harming someone even though you didn't want to, or fearing you would act on some impulse, or fear or superstitions that you would be responsible for things going wrong, or obsessions with sexual thoughts, images or impulses, or hoarding, collecting, or religious obsessions.)

(DO NOT INCLUDE SIMPLY EXCESSIVE WORRIES ABOUT REAL LIFE PROBLEMS. DO NOT INCLUDE OBSESSIONS DIRECTLY RELATED TO EATING DISORDERS, SEXUAL DEVIATIONS, PATHOLOGICAL GAMBLING, OR ALCOHOL OR DRUG ABUSE BECAUSE THE PATIENT MAY DERIVE PLEASURE FROM THE ACTIVITY AND MAY WANT TO RESIST IT ONLY BECAUSE OF ITS NEGATIVE CONSEQUENCES.)

NO YES
↓
SKIP TO H4

H2 Did they keep coming back into your mind even when you tried to ignore or get rid of them?

NO YES
↓
SKIP TO H4

H3 Do you think that these obsessions are the product of your own mind and that they are not imposed from the outside?

NO YES
obsessions

H4 In the past month, did you do something repeatedly without being able to resist doing it, like washing or cleaning excessively, counting or checking things over and over, or repeating, collecting, arranging things, or other superstitious rituals?

NO YES
compulsions

IS H3 OR H4 CODED YES?

⇨
NO YES

H5 Did you recognize that either these obsessive thoughts or these compulsive behaviors were excessive or unreasonable?

⇨
NO YES

H6 Did these obsessive thoughts and/or compulsive behaviors significantly interfere with your normal routine, your work or school, your usual social activities, or relationships, or did they take more than one hour a day?

NO YES

O.C.D. CURRENT

I. POSTTRAUMATIC STRESS DISORDER (optional)

(➪ MEANS : GO TO THE DIAGNOSTIC BOX, CIRCLE NO, AND MOVE TO THE NEXT MODULE)

		➪ NO	YES
I1	Have you ever experienced or witnessed or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else? EXAMPLES OF TRAUMATIC EVENTS INCLUDE: SERIOUS ACCIDENTS, SEXUAL OR PHYSICAL ASSAULT, A TERRORIST ATTACK, BEING HELD HOSTAGE, KIDNAPPING, FIRE, DISCOVERING A BODY, SUDDEN DEATH OF SOMEONE CLOSE TO YOU, WAR, OR NATURAL DISASTER.		
I2	Did you respond with intense fear, helplessness or horror?	➪ NO	YES
I3	During the past month, have you re-experienced the event in a distressing way (such as, dreams, intense recollections, flashbacks or physical reactions)?	➪ NO	YES
I4	**In the past month:**	NO	YES
a	Have you avoided thinking about or talking about the event ?	NO	YES
b	Have you avoided activities, places or people that remind you of the event?	NO	YES
c	Have you had trouble recalling some important part of what happened?	NO	YES
d	Have you become much less interested in hobbies or social activities?	NO	YES
e	Have you felt detached or estranged from others?	NO	YES
f	Have you noticed that your feelings are numbed?	NO	YES
g	Have you felt that your life will be shortened or that you will die sooner than other people?	➪ NO	YES
	ARE 3 OR MORE I4 ANSWERS CODED YES?		
I5	**In the past month:**	NO	YES
a	Have you had difficulty sleeping?	NO	YES
b	Were you especially irritable or did you have outbursts of anger?	NO	YES
c	Have you had difficulty concentrating?	NO	YES
d	Were you nervous or constantly on your guard?	NO	YES
e	Were you easily startled?	➪ NO	YES
	ARE 2 OR MORE I5 ANSWERS CODED YES?		
I6	During the past month, have these problems significantly interfered with your work or social activities, or caused significant distress?	NO	YES

POSTTRAUMATIC STRESS DISORDER CURRENT

J. ALCOHOL ABUSE AND DEPENDENCE

(⇨ MEANS: GO TO DIAGNOSTIC BOXES, CIRCLE NO IN BOTH AND MOVE TO THE NEXT MODULE)

		⇨ NO	YES
J1	**In the past 12 months**, have you had 3 or more alcoholic drinks within a 3 hour period on 3 or more occasions?		

J2 **In the past 12 months:**

a	Did you need to drink more in order to get the same effect that you got when you first started drinking?	NO	YES
b	When you cut down on drinking did your hands shake, did you sweat or feel agitated? Did you drink to avoid these symptoms or to avoid being hungover, for example, "the shakes", sweating or agitation? IF YES TO EITHER, CODE YES.	NO	YES
c	During the times when you drank alcohol, did you end up drinking more than you planned when you started?	NO	YES
d	Have you tried to reduce or stop drinking alcohol but failed?	NO	YES
e	On the days that you drank, did you spend substantial time in obtaining alcohol, drinking, or in recovering from the effects of alcohol?	NO	YES
f	Did you spend less time working, enjoying hobbies, or being with others because of your drinking?	NO	YES
g	Have you continued to drink even though you knew that the drinking caused you health or mental problems?	NO	YES

ARE 3 OR MORE J2 ANSWERS CODED YES?

NO YES*

* IF YES, SKIP J3 QUESTIONS, CIRCLE N/A IN THE ABUSE BOX AND MOVE TO THE NEXT DISORDER. DEPENDENCE PREEMPTS ABUSE.

ALCOHOL DEPENDENCE CURRENT

J3 **In the past 12 months:**

a	Have you been intoxicated, high, or hungover more than once when you had other responsibilities at school, at work, or at home? Did this cause any problems? (CODE YES ONLY IF THIS CAUSED PROBLEMS.)	NO	YES
b	Were you intoxicated more than once in any situation where you were physically at risk, for example, driving a car, riding a motorbike, using machinery, boating, etc.?	NO	YES
c	Did you have legal problems more than once because of your drinking, for example, an arrest or disorderly conduct?	NO	YES
d	Did you continue to drink even though your drinking caused problems with your family or other people?	NO	YES

ARE 1 OR MORE J3 ANSWERS CODED YES?

NO N/A YES

ALCOHOL ABUSE CURRENT

K. NON-ALCOHOL PSYCHOACTIVE SUBSTANCE USE DISORDERS

(➡ MEANS : GO TO THE DIAGNOSTIC BOXES, CIRCLE NO IN ALL DIAGNOSTIC BOXES, AND MOVE TO THE NEXT MODULE)

Now I am going to show you / read to you a list of street drugs or medicines.

			➡ NO	YES
K1	a	**In the past 12 months,** did you take any of these drugs more than once, to get high, to feel better, or to change your mood?		

CIRCLE EACH DRUG TAKEN:

Stimulants: amphetamines, "speed", crystal meth, "crank", "rush", Dexedrine, Ritalin, diet pills.

Cocaine: snorting, IV, freebase, crack, "speedball".

Narcotics: heroin, morphine, Dilaudid, opium, Demerol, methadone, codeine, Percodan, Darvon, OxyContin.

Hallucinogens: LSD ("acid"), mescaline, peyote, PCP ("angel dust", "peace pill"), psilocybin, STP, "mushrooms", "ecstasy", MDA, MDMA, or ketamine ("special K").

Inhalants: "glue", ethyl chloride, "rush", nitrous oxide ("laughing gas"), amyl or butyl nitrate ("poppers").

Marijuana: hashish ("hash"), THC, "pot", "grass", "weed", "reefer".

Tranquilizers: Quaalude, Seconal ("reds"), Valium, Xanax, Librium, Ativan, Dalmane, Halcion, barbiturates, Miltown, GHB, Roofinol, "Roofies".

Miscellaneous: steroids, nonprescription sleep or diet pills. Any others?

SPECIFY MOST USED DRUG(S): _____

CHECK ONE BOX

ONLY ONE DRUG / DRUG CLASS HAS BEEN USED ☐

ONLY THE MOST USED DRUG CLASS IS INVESTIGATED. ☐

EACH DRUG CLASS USED IS EXAMINED SEPARATELY (PHOTOCOPY K2 AND K3 AS NEEDED) ☐

b SPECIFY WHICH DRUG/DRUG CLASS WILL BE EXPLORED IN THE INTERVIEW BELOW IF THERE IS CONCURRENT OR SEQUENTIAL POLYSUBSTANCE USE: _____

K2 **Considering your use of (NAME THE DRUG / DRUG CLASS SELECTED), in the past 12 months:**

		NO	YES
a	Have you found that you needed to use more (NAME OF DRUG / DRUG CLASS SELECTED) to get the same effect that you did when you first started taking it?		
b	When you reduced or stopped using (NAME OF DRUG / DRUG CLASS SELECTED), did you have withdrawal symptoms (aches, shaking, fever, weakness, diarrhea, nausea, sweating, heart pounding, difficulty sleeping, or feeling agitated, anxious, irritable, or depressed)? Did you use any drug(s) to keep yourself from getting sick (withdrawal symptoms) or so that you would feel better? IF YES TO EITHER, CODE YES.		
c	Have you often found that when you used (NAME OF DRUG / DRUG CLASS SELECTED), you ended up taking more than you thought you would?		
d	Have you tried to reduce or stop taking (NAME OF DRUG / DRUG CLASS SELECTED) but failed?		
e	On the days that you used (NAME OF DRUG / DRUG CLASS SELECTED), did you spend substantial time (>2 HOURS), obtaining, using or in recovering from the drug, or thinking about the drug?		

f Did you spend less time working, enjoying hobbies, or being with family or friends because of your drug use? NO YES

g Have you continued to use (NAME OF DRUG / DRUG CLASS SELECTED), even though it caused you health or mental problems? NO YES

ARE 3 OR MORE K2 ANSWERS CODED YES?

SPECIFY DRUG(S): _____

NO YES *

SUBSTANCE DEPENDENCE
CURRENT

* IF YES, SKIP K3 QUESTIONS, CIRCLE N/A IN THE ABUSE BOX FOR THIS SUBSTANCE AND MOVE TO THE NEXT DISORDER.
DEPENDENCE PREEMPTS ABUSE.

Considering your use of (NAME THE DRUG CLASS SELECTED), in the past 12 months:

K3 a Have you been intoxicated, high, or hungover from (NAME OF DRUG / DRUG CLASS SELECTED) more than once, when you had other responsibilities at school, at work, or at home? Did this cause any problem? NO YES

(CODE YES ONLY IF THIS CAUSED PROBLEMS.)

b Have you been high or intoxicated from (NAME OF DRUG / DRUG CLASS SELECTED) more than once in any situation where you were physically at risk (for example, driving a car, riding a motorbike, using machinery, boating, etc.)? NO YES

c Did you have legal problems more than once because of your drug use, for example, an arrest or disorderly conduct? NO YES

d Did you continue to use (NAME OF DRUG / DRUG CLASS SELECTED), even though it caused problems with your family or other people? NO YES

ARE 1 OR MORE K3 ANSWERS CODED YES?

SPECIFY DRUG(S): _____

NO N/A YES

SUBSTANCE ABUSE
CURRENT

L. PSYCHOTIC DISORDERS AND MOOD DISORDER WITH PSYCHOTIC FEATURES

ASK FOR AN EXAMPLE OF EACH QUESTION ANSWERED POSITIVELY. CODE YES ONLY IF THE EXAMPLES CLEARLY SHOW A DISTORTION OF THOUGHT OR OF PERCEPTION OR IF THEY ARE NOT CULTURALLY APPROPRIATE. BEFORE CODING, INVESTIGATE WHETHER DELUSIONS QUALIFY AS "BIZARRE".

DELUSIONS ARE "BIZARRE" IF: CLEARLY IMPLAUSIBLE, ABSURD, NOT UNDERSTANDABLE, AND CANNOT DERIVE FROM ORDINARY LIFE EXPERIENCE.

HALLUCINATIONS ARE SCORED "BIZARRE" IF: A VOICE COMMENTS ON THE PERSON'S THOUGHTS OR BEHAVIOR, OR WHEN TWO OR MORE VOICES ARE CONVERSING WITH EACH OTHER.

Now I am going to ask you about unusual experiences that some people have.

					BIZARRE
L1	a	Have you ever believed that people were spying on you, or that someone was plotting against you, or trying to hurt you? NOTE: ASK FOR EXAMPLES TO RULE OUT ACTUAL STALKING.	NO	YES	YES
	b	**IF YES OR YES BIZARRE:** do you currently believe these things?	NO	YES	YES ⇨L6
L2	a	Have you ever believed that someone was reading your mind or could hear your thoughts, or that you could actually read someone's mind or hear what another person was thinking?	NO	YES	YES
	b	**IF YES OR YES BIZARRE:** do you currently believe these things?	NO	YES	YES ⇨L6
L3	a	Have you ever believed that someone or some force outside of yourself put thoughts in your mind that were not your own, or made you act in a way that was not your usual self? Have you ever felt that you were possessed? CLINICIAN: ASK FOR EXAMPLES AND DISCOUNT ANY THAT ARE NOT PSYCHOTIC.	NO	YES	YES
	b	**IF YES OR YES BIZARRE:** do you currently believe these things?	NO	YES	YES ⇨L6
L4	a	Have you ever believed that you were being sent special messages through the TV, radio, or newspaper, or that a person you did not personally know was particularly interested in you?	NO	YES	YES
	b	**IF YES OR YES BIZARRE:** do you currently believe these things?	NO	YES	YES ⇨L6
L5	a	Have your relatives or friends ever considered any of your beliefs strange or unusual? INTERVIEWER: ASK FOR EXAMPLES. ONLY CODE YES IF THE EXAMPLES ARE CLEARLY DELUSIONAL IDEAS NOT EXPLORED IN QUESTIONS L1 TO L4, FOR EXAMPLE, SOMATIC OR RELIGIOUS DELUSIONS OR DELUSIONS OF GRANDIOSITY, JEALOUSY, GUILT, RUIN OR DESTITIUTION, ETC.	NO	YES	YES
	b	**IF YES OR YES BIZARRE:** do they currently consider your beliefs strange?	NO	YES	YES
L6	a	Have you ever heard things other people couldn't hear, such as voices? HALLUCINATIONS ARE SCORED "BIZARRE" ONLY IF PATIENT ANSWERS YES TO THE FOLLOWING:	NO	YES	
		IF YES: Did you hear a voice commenting on your thoughts or behavior or did you hear two or more voices talking to each other?	NO		YES
	b	**IF YES OR YES BIZARRE TO L6a:** have you heard these things in the past month? HALLUCINATIONS ARE SCORED "BIZARRE" ONLY IF PATIENT ANSWERS YES TO THE FOLLOWING: Did you hear a voice commenting on your thoughts or behavior or did you hear two or more voices talking to each other?	NO	YES	YES ⇨L8b

L7 a Have you ever had visions when you were awake or have you ever seen things other people couldn't see? NO YES

CLINICIAN: CHECK TO SEE IF THESE ARE CULTURALLY INAPPROPRIATE.

b **IF YES:** have you seen these things in the past month? NO YES

CLINICIAN'S JUDGMENT

L8 b IS THE PATIENT CURRENTLY EXHIBITING INCOHERENCE, DISORGANIZED SPEECH, OR MARKED LOOSENING OF ASSOCIATIONS? NO YES

L9 b IS THE PATIENT CURRENTLY EXHIBITING DISORGANIZED OR CATATONIC BEHAVIOR? NO YES

L10 b ARE NEGATIVE SYMPTOMS OF SCHIZOPHRENIA, E.G. SIGNIFICANT AFFECTIVE FLATTENING, POVERTY OF SPEECH (ALOGIA) OR AN INABILITY TO INITIATE OR PERSIST IN GOAL-DIRECTED ACTIVITIES (AVOLITION), PROMINENT DURING THE INTERVIEW? NO YES

L11 a ARE 1 OR MORE « a » QUESTIONS FROM L1a TO L7a CODED **YES OR YES BIZARRE** AND IS EITHER:

MAJOR DEPRESSIVE EPISODE, (CURRENT OR RECURRENT)
OR
MANIC OR HYPOMANIC EPISODE, (CURRENT OR PAST) CODED **YES**? NO ⇨L13 YES

IF NO TO L11 a, CIRCLE NO IN BOTH 'MOOD DISORDER WITH PSYCHOTIC FEATURES' DIAGNOSTIC BOXES AND MOVE TO L13.

b You told me earlier that you had period(s) when you felt (depressed/high/persistently irritable).

Were the beliefs and experiences you just described (SYMPTOMS CODED YES FROM L1a TO L7a) restricted exclusively to times when you were feeling depressed/high/irritable?

IF THE PATIENT EVER HAD A PERIOD OF AT LEAST 2 WEEKS OF HAVING THESE BELIEFS OR EXPERIENCES (PSYCHOTIC SYMPTOMS) WHEN THEY WERE NOT DEPRESSED/HIGH/IRRITABLE, CODE NO TO THIS DISORDER.

IF THE ANSWER IS NO TO THIS DISORDER, ALSO CIRCLE NO TO L12 AND MOVE TO L13

NO YES

MOOD DISORDER WITH PSYCHOTIC FEATURES

LIFETIME

L12 a ARE 1 OR MORE « b » QUESTIONS FROM L1b TO L7b CODED **YES OR YES BIZARRE** AND IS EITHER:

MAJOR DEPRESSIVE EPISODE, (CURRENT)
OR
MANIC OR HYPOMANIC EPISODE, (CURRENT) CODED **YES**?

IF THE ANSWER IS YES TO THIS DISORDER (LIFETIME OR CURRENT), CIRCLE NO TO L13 AND L14 AND MOVE TO THE NEXT MODULE.

NO YES

MOOD DISORDER WITH PSYCHOTIC FEATURES

CURRENT

L13 ARE 1 OR MORE « b » QUESTIONS FROM L1b TO L6b, CODED **YES BIZARRE**?

OR

ARE 2 OR MORE « b » QUESTIONS FROM L1b TO L10b, CODED **YES** (RATHER THAN **YES BIZARRE**)?

AND DID AT LEAST TWO OF THE PSYCHOTIC SYMPTOMS OCCUR DURING THE SAME 1 MONTH PERIOD?

NO YES

PSYCHOTIC DISORDER
CURRENT

L14 IS **L13 CODED YES**

OR

ARE 1 OR MORE « a » QUESTIONS FROM L1a TO L6a, CODED **YES BIZARRE**?

OR

ARE 2 OR MORE « a » QUESTIONS FROM L1a TO L7a, CODED **YES** (RATHER THAN **YES BIZARRE**)

AND DID AT LEAST TWO OF THE PSYCHOTIC SYMPTOMS OCCUR DURING THE SAME 1 MONTH PERIOD?

NO YES

PSYCHOTIC DISORDER
LIFETIME

M. ANOREXIA NERVOSA

(⇨ MEANS : GO TO THE DIAGNOSTIC BOX, CIRCLE NO, AND MOVE TO THE NEXT MODULE)

M1 a How tall are you? ☐ft ☐☐in. / ☐☐☐cm.

b. What was your lowest weight in the past 3 months? ☐☐☐lbs. / ☐☐☐kgs.

⇨

c IS PATIENT'S WEIGHT EQUAL TO OR BELOW THE THRESHOLD CORRESPONDING TO HIS / HER HEIGHT? (SEE TABLE BELOW) NO YES

In the past 3 months:

⇨

M2 In spite of this low weight, have you tried not to gain weight? NO YES

⇨

M3 Have you intensely feared gaining weight or becoming fat, even though you were underweight? NO YES

M4 a Have you considered yourself too big / fat or that part of your body was too big / fat? NO YES

b Has your body weight or shape greatly influenced how you felt about yourself? NO YES

c Have you thought that your current low body weight was normal or excessive? NO YES

⇨

M5 ARE 1 OR MORE ITEMS FROM M4 CODED YES? NO YES

⇨

M6 FOR WOMEN ONLY: During the last 3 months, did you miss all your menstrual periods when they were expected to occur (when you were not pregnant)? NO YES

FOR WOMEN: ARE M5 AND M6 CODED YES?

FOR MEN: IS M5 CODED YES?

NO YES

ANOREXIA NERVOSA CURRENT

HEIGHT / WEIGHT TABLE CORRESPONDING TO A BMI THRESHOLD OF 17.5 KG/M²

Height/Weight														
ft/in	4'9	4'10	4'11	5'0	5'1	5'2	5'3	5'4	5'5	5'6	5'7	5'8	5'9	5'10
lbs.	81	84	87	89	92	96	99	102	105	108	112	115	118	122
cm	145	147	150	152	155	158	160	163	165	168	170	173	175	178
kgs	37	38	39	41	42	43	45	46	48	49	51	52	54	55

Height/Weight					
ft/in	5'11	6'0	6'1	6'2	6'3
lbs.	125	129	132	136	140
cm	180	183	185	188	191
kgs	57	59	60	62	64

The weight thresholds above are calculated using a body mass index (BMI) equal to or below 17.5 kg/m² for the patient's height. This is the threshold guideline below which a person is deemed underweight by the DSM-IV and the ICD-10 Diagnostic Criteria for Research for Anorexia Nervosa.

N. BULIMIA NERVOSA

(➡ MEANS : GO TO THE DIAGNOSTIC BOXES, CIRCLE NO IN ALL DIAGNOSTIC BOXES, AND MOVE TO THE NEXT MODULE)

N1	In the past three months, did you have eating binges or times when you ate a very large amount of food within a 2-hour period?	➡ NO YES
N2	In the last 3 months, did you have eating binges as often as twice a week?	➡ NO YES
N3	During these binges, did you feel that your eating was out of control?	➡ NO YES
N4	Did you do anything to compensate for, or to prevent a weight gain from these binges, like vomiting, fasting, exercising or taking laxatives, enemas, diuretics (fluid pills), or other medications?	➡ NO YES
N5	Does your body weight or shape greatly influence how you feel about yourself?	NO YES
N6	DO THE PATIENT'S SYMPTOMS MEET CRITERIA FOR ANOREXIA NERVOSA?	NO YES ↓ Skip to N8
N7	Do these binges occur only when you are under (_____lbs./kgs.)? INTERVIEWER: WRITE IN THE ABOVE PARENTHESIS THE THRESHOLD WEIGHT FOR THIS PATIENT'S HEIGHT FROM THE HEIGHT / WEIGHT TABLE IN THE ANOREXIA NERVOSA MODULE.	NO YES
N8	IS N5 CODED YES AND IS EITHER N6 OR N7 CODED NO?	NO YES *BULIMIA NERVOSA* CURRENT
	IS N7 CODED YES?	NO YES *ANOREXIA NERVOSA* *Binge Eating/Purging Type* CURRENT

O. GENERALIZED ANXIETY DISORDER

(⇨ MEANS : GO TO THE DIAGNOSTIC BOX, CIRCLE NO, AND MOVE TO THE NEXT MODULE)

O1	a	Have you worried excessively or been anxious about several things over the past 6 months?	⇨ NO YES
	b	Are these worries present most days?	⇨ NO YES
		IS THE PATIENT'S ANXIETY RESTRICTED EXCLUSIVELY TO, OR BETTER EXPLAINED BY, ANY DISORDER PRIOR TO THIS POINT?	⇨ NO YES
O2		Do you find it difficult to control the worries or do they interfere with your ability to focus on what you are doing?	⇨ NO YES
O3		FOR THE FOLLOWING, CODE NO IF THE SYMPTOMS ARE CONFINED TO FEATURES OF ANY DISORDER EXPLORED PRIOR TO THIS POINT.	
		When you were anxious over the past 6 months, did you, most of the time:	
	a	Feel restless, keyed up or on edge?	NO YES
	b	Feel tense?	NO YES
	c	Feel tired, weak or exhausted easily?	NO YES
	d	Have difficulty concentrating or find your mind going blank?	NO YES
	e	Feel irritable?	NO YES
	f	Have difficulty sleeping (difficulty falling asleep, waking up in the middle of the night, early morning wakening or sleeping excessively)?	NO YES
		ARE 3 OR MORE O3 ANSWERS CODED YES?	NO YES

GENERALIZED ANXIETY DISORDER CURRENT

P. ANTISOCIAL PERSONALITY DISORDER (optional)

(⇨ MEANS : GO TO THE DIAGNOSTIC BOX AND CIRCLE NO.)

P1 **Before you were 15 years old, did you:**

a	repeatedly skip school or run away from home overnight?	NO	YES
b	repeatedly lie, cheat, "con" others, or steal?	NO	YES
c	start fights or bully, threaten, or intimidate others?	NO	YES
d	deliberately destroy things or start fires?	NO	YES
e	deliberately hurt animals or people?	NO	YES
f	force someone to have sex with you?	NO ⇨	YES
	ARE 2 OR MORE P1 ANSWERS CODED YES?	NO	YES

DO NOT CODE YES TO THE BEHAVIORS BELOW IF THEY ARE EXCLUSIVELY POLITICALLY OR RELIGIOUSLY MOTIVATED.

P2 **Since you were 15 years old, have you:**

a	repeatedly behaved in a way that others would consider irresponsible, like failing to pay for things you owed, deliberately being impulsive or deliberately not working to support yourself?	NO	YES
b	done things that are illegal even if you didn't get caught (for example, destroying property, shoplifting, stealing, selling drugs, or committing a felony)?	NO	YES
c	been in physical fights repeatedly (including physical fights with your spouse or children)?	NO	YES
d	often lied or "conned" other people to get money or pleasure, or lied just for fun?	NO	YES
e	exposed others to danger without caring?	NO	YES
f	felt no guilt after hurting, mistreating, lying to, or stealing from others, or after damaging property?	NO	YES

ARE 3 OR MORE P2 QUESTIONS CODED YES?

NO YES

ANTISOCIAL PERSONALITY DISORDER
LIFETIME

THIS CONCLUDES THE INTERVIEW

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name _____ Today's Date _____

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.

Part A	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					
Part B					
7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					